Aflac™
An Independent Agent Representing Aflac

FAX
Cover sheet

Attn: Heather

Fax: (281) 907-8845
or
Heather_kirk@us.aflac.com

Fax

To: Heather Kirk -

From:

Fax: 1 (281) 907-8845

Pages:

Phone: CALL (281) 440-1133 ext 123

Date:

Re:

Phone:

FAX:

REQUEST FOR CHANGE

Fax No.: 706.660.7278

EMPLOYEE NO:_____ **BENEFITS OFFICE ONLY**

Group Policyholder: CITY OF HOUSTON - No. 84423 Effective Date of Change: _____ / _____ / _____

Employee Name_____ Social Security Number: _____ -_____ - _____

First M.I. Last

Current Mailing Address: _____ **(CHECK IF THIS IS AN ADDRESS CHANGE ONLY [ ])**

City: _____ State: _____ ZIP Code: _____

Department:_____ Work Phone: (____) _____ - _____ Cell or Home Phone: (____) _____ - _____

POLICY: [ ] Personal Cancer Protector Plan [ ] Voluntary Indemnity Plan (Hospital) [ ] Personal Accident Expense Plan

PLEASE MAKE THE FOLLOWING CHANGES:

Full Name (First, M, Last) Date of Birth Relationship

[ ] ADDITIONS ONLY _____

_____

Reason: [ ] Marriage [ ] Divorce [ ] Other _____ Date of Event: _____ / _____ / _____

Type of Coverage now desired: [ ] Individual [ ] Individual & Spouse [ ] One-Parent Family [ ] Two-Parent Family

Full Name (First, M, Last) Date of Birth Relationship

[ ] DELETIONS ONLY _____

_____

Reason: [ ] Divorce [ ] Other: _____ Date of Event: _____ / _____ / _____

Type of Coverage now desired: [ ] Individual [ ] Individual & Spouse [ ] One-Parent Family [ ] Two-Parent Family

[ ] NAME CHANGE ONLY Name shown on policy: _____

Change name to: _____

Reason: [ ] Marriage [ ] Divorce [ ] Other: _____ Date of Event: _____ / ___ ___ / _____

Type of Coverage now desired: [ ] Individual [ ] Individual & Spouse [ ] One-Parent Family [ ] Two-Parent Family

[ ] CANCELATION ONLY I, the principal insured/owner on the above-mentioned policy, wish to cancel the AFLAC plan and/or plans I have checked above. My current AFLAC tax status is: [ ] PRE-TAX [ ] POST-TAX

[ ] BENEFICIARY CHANGE ONLY Change my Beneficiary to the following designated person.

_____

Last Name First M.I. Relationship Age

IMPORTANT: READ BEFORE SIGNING & PLEASE ANSWER QUESTION FOR ALL ADDITIONS

To the best of my knowledge no one to be **ADDED** under the terms of my **CANCER** policy has ever been diagnosed or treated for any of the following conditions:

• cancer of any type or form • acquired immune deficiency syndrome (AIDS) • AIDS-related complex (ARC).

HOSPTIAL INDEMNITY PLAN/ QUESTIONS REQUIRED FOR ADDITIONS:

(1) Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? **[ ]** Yes **[ ]** No

(2) Has anyone to be covered been confined in a hospital or nursing home within the last 24 months because of internal cancer, heart surgery, heart attack or congestive heart failure ore been confined to a nursing home with the past 12 months for chronic liver disease, stroke, emphysema, chronic bronchitis, or Parkinson's disease? [ ] Yes [ ] No

(3) Has anyone to be covered ever been treated for or diagnosed as having Alzheimer's disease, senile dementia, systemic lupus, kidney failure, insulin dependent diabetes, AIDS or ARC (Aids Related Complex)? [ ] Yes [ ] No

(4) If Question 1, 2 or 3 was checked **YES** the person's name and relationship must be shown in the following space. ANY PERSON(S) SO NAMED WILL NOT BE COVERED UNDER THE POLICY.

_____ _____

Name Relationship Name Relationship

Employee Signature: _____ Date: _____/_____ /__ _____

BENEFITS OFFICE ONLY:

AUTHORIZED BY:_____ Date: _____/____ / _____

(City of Houston Aflac Plan Administrator)

Aflac coverage is underwritten by American Family Life Assurance Company of Columbus.
Worldwide Headquarters: 1932 Wynnton Rd. Columbus, GA 31999